

# Post Exposure Name-Address-Phone & History (NAPH) Form

## Sections I and II – To Be Completed By Person Picking Up Medications

Date: \_\_\_\_\_ Site: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_

### I. INFORMATION (person picking up medications)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

#### If under age 18 years

Name of guardian \_\_\_\_\_

Contact phone number \_\_\_\_\_

#### People you are picking up medications for (include last name if different from yours)

	Name	DOB
1.	(you)	
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Sections I & II RECEPTION

### II. ACKNOWLEDGEMENT/CONSENT (person picking up medications)

I am picking up medications for myself and/or others that live in my household or for someone who is unable to pick up their own medications.

▪ NO ONE IN MY RESIDENCE IS RECEIVING ADDITIONAL MEDICATIONS AT OTHER SITES

I am seeking medication in accordance with Centers for Disease Control and Prevention (CDC) guidelines and the state and county health department. I have received information about the disease and medications. I consent to take the medications.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**STOP**

**STOP**

**STOP**

*Do not fill out any of the information beyond this point before being instructed to do so.*

Make sure you have read and understand the Patient Information Sheets that have been provided to you. If you have questions, you will have an opportunity to ask them at the Registration Table (Red Table).

### III. HISTORY of all receiving medication - Use a HI-LITER to fill in the appropriate box for Yes and No

- |   |                              |                             |                               |                              |                             |                             |                              |                             |
|---|------------------------------|-----------------------------|-------------------------------|------------------------------|-----------------------------|-----------------------------|------------------------------|-----------------------------|
| 1. Epilepsy and/or Kidney Disease           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 5. Allergic to Doxycycline:   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 8. Allergic to Medications: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Kidney Dialysis                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 6. Allergic to Ciprofloxacin: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 8a. List: _____             |                              |                             |
| 3. Pregnant and/or Breastfeeding            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 7. Allergic to Amoxicillin:   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____                       |                              |                             |
| 4. Are there children/persons under 60 lbs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                               |                              |                             | _____                       |                              |                             |

(If ALL answers are no, send patients to the Green Table. If there is a yes to ANY question, send patients to the Blue Table w/ names in section IV)

### IV. ASSESSMENT (Use a HI-LITER to fill in the appropriate “yes” response per patient marked in the HISTORY section)

	1	2	3	4	5	6	7	9	10	11
Name (First Name of <u>all</u> persons)	Condition (Epilepsy, Kidney Disease)	Condition (Kidney Dialysis)	Condition (Pregnant, Breastfeeding)	Weight (ONLY if less than 60lbs)	Allergy Doxy	Allergy Cipro	Allergy Amox	List Prescription Medication	List Amount	Check box when dispensed
1. (you)	Yes 1	Yes 2	Yes 3	Yes 4	Yes 5	Yes 6	Yes 7	Doxy Cipro Amox _____	1 ½ ¼ _____ml	<input type="checkbox"/>
2.	Yes 1	Yes 2	Yes 3	Yes 4	Yes 5	Yes 6	Yes 7	Doxy Cipro Amox _____	1 ½ ¼ _____ml	<input type="checkbox"/>
3.	Yes 1	Yes 2	Yes 3	Yes 4	Yes 5	Yes 6	Yes 7	Doxy Cipro Amox _____	1 ½ ¼ _____ml	<input type="checkbox"/>
4.	Yes 1	Yes 2	Yes 3	Yes 4	Yes 5	Yes 6	Yes 7	Doxy Cipro Amox _____	1 ½ ¼ _____ml	<input type="checkbox"/>
5.	Yes 1	Yes 2	Yes 3	Yes 4	Yes 5	Yes 6	Yes 7	Doxy Cipro Amox _____	1 ½ ¼ _____ml	<input type="checkbox"/>
6.	Yes 1	Yes 2	Yes 3	Yes 4	Yes 5	Yes 6	Yes 7	Doxy Cipro Amox _____	1 ½ ¼ _____ml	<input type="checkbox"/>
7.	Yes 1	Yes 2	Yes 3	Yes 4	Yes 5	Yes 6	Yes 7	Doxy Cipro Amox _____	1 ½ ¼ _____ml	<input type="checkbox"/>
8.	Yes 1	Yes 2	Yes 3	Yes 4	Yes 5	Yes 6	Yes 7	Doxy Cipro Amox _____	1 ½ ¼ _____ml	<input type="checkbox"/>
9.	Yes 1	Yes 2	Yes 3	Yes 4	Yes 5	Yes 6	Yes 7	Doxy Cipro Amox _____	1 ½ ¼ _____ml	<input type="checkbox"/>
10.	Yes 1	Yes 2	Yes 3	Yes 4	Yes 5	Yes 6	Yes 7	Doxy Cipro Amox _____	1 ½ ¼ _____ml	<input type="checkbox"/>

### V. INTERVENTIONS: Informed identified patients of the following:

- |                  |  |
|------------------|--|
| Patient #: _____ | A. Doxy and/or Cipro should not be taken longer than 14 days. Contact your physician as soon as possible about your medications. |
| Patient #: _____ | B. Call the Pharmacy Hotline for proper medication and dosage.   |
| Patient #: _____ | C. Patient must go offsite to collect certain medications.   |
| Patient #: _____ | D. Site consultation provided.   |
| Patient #: _____ | E. _____   |

Section III  
REGISTRATION

Section IV Initiated at Registration Table & Completed at Assessment Table

Section V  
A.I. Stations